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Looked-After Children's Views of Sex and Relationships Education and Sexual Health Services

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1 Introduction

This document reports on the findings from a project exploring teenage looked-after children's views of sex and relationships education and sexual health services. Commissioned and funded by the Kent Teenage Pregnancy Partnership, this project formed part of a larger programme of study on teenage pregnancy that took place across Kent between 2004 and 2007.

1.1 Background

The research was carried out as part of a broader study into teenagers' views and experiences of sex and relationship education, sexual health services and family support services in Kent. The project was composed of three parts:

- **Project One** constituted the quantitative part of our research, which included a survey carried out with 4000 15 to 16 year old school pupils;

- **Project Two** (which this document reports upon) gauged the attitudes and experiences of looked-after children regarding sexual health education and relationships advice by conducting focus groups with 20 15 to 20 year olds;

- **Project Three** was a longitudinal qualitative study exploring the views of teenage parents during the antenatal and postnatal periods. It was concerned with finding out their experiences of family support services, as well as obtaining their views on sex and relationships education and sexual health services;

The rationale behind Project Two was to ensure the incorporation of the views of more 'vulnerable' teenagers, who were considered less likely to be included in the survey sample of school-children. Looked-after children have recently come into policy focus as part of Government strategies aimed at reducing teenage pregnancy and in their own right (see for example, the 'Care Matters' consultation process by the Department for Education and Skills). The recently published Government Paper on Teenage Pregnancy, 'Accelerating the Strategy to 2010' (2006) included a specific focus on children and young people in care, who have been identified as especially vulnerable to teenage pregnancy. The Government made the following tasks a priority –

- Include specialist training modules on sex and relationships in the new training and qualifications framework for foster and residential careers, making clear children and young people in care's heightened risk of early sex and pregnancy;

- Provide resources to help schools, carers and social workers establish a shared approach to SRE for children and young people in care, to make sure they receive consistent messages and support, in and out of school;

- Provide SRE training modules for Local Authorities to offer leaving care teams – in early 2007;

- Provide, in early 2007, an easy to use SRE toolkit for carers and designated teachers for children and young people in care, to help them discuss sex and relationships issues – with a focus on helping young people develop the confidence to delay early sex and access early contraceptive advice when they do become sexually active

(Teenage Pregnancy: Accelerating the Strategy to 2010, Teenage Pregnancy Unit, 2006: 28-29)

In the light of these recommendations, the research on looked-after young people offers a unique insight into the experiences and opinions of this target group in the Kent region. The work shows that looked-after young people have specific needs concerning sexual health education and advice which have not been addressed through school, foster care or looked-after support services. The study identifies the problems encountered in gaining knowledge, accessing services and taking control of their sexual lives. It also suggests ways in which these issues could be addressed.

The particular vulnerability of looked-after young people is well-established (Garnett and National Children's 1992; Williams, Jackson et al. 2001; Wilding and Barton 2003; Cocker and Scott 2006). During their time in public care and after leaving it, looked-after young people have been found to be significantly disadvantaged, often in addition to the problems which initially brought them into the care system. Problems finding employment, poor housing, high rates of offending and imprisonment, drug and alcohol use, poor mental and physical health (Polnay and Ward 2000) have all been associated with having spent time in local authority care. Cocker and Salt (2006) suggest that looked-after children have weakened resources of 'resilience-promoting factors' such as parental support, positive educational experiences and strong social networks. In addition, young people in and post public care have been shown to become sexually active at

a younger age and to have higher rates of teenage pregnancy and parenthood. While in policy terms, this is understood as contributing to a 'cycle of deprivation and exclusion', studies of looked-after young people have found that becoming a parent while a teenager is not necessarily regarded as overwhelmingly negative by the teenagers themselves and is often credited with improving their lives and helping them to mature and create meaningful identities and relationships (Rolfe 2000; Wilding and Barton 2003; Cater, Coleman et al. 2006). However, given the relative lack of support and sexual vulnerability experienced by looked-after children, ensuring that they have maximum control of their fertility and sexual health should be a high priority. This study aims to explore the particular experience of looked-after children in Kent, an area with high levels of looked-after children, some of whom have come from outside the area, compounding their isolation and the level of disruption they face. However, other regional studies of looked-after children have found similar problems of inconsistency in sex education, disrupted schooling, issues of trust and problems accessing sexual health services (Wilding and Barton 2003).

1.2 Aims

The aims of the study with the looked-after young people were to –

- Describe teenagers' awareness and understanding of sexual health services and to discover the up-take, strengths and weaknesses of any sexual health services used in the community

- Describe how teenagers currently get information about sexual health and relationships and the value placed on these sources

- Explore the nature, strengths and weaknesses of sexual health and relationships education received

- Describe the extent to which sex and relationships education and health services have prepared young people for sexual relationships

- Identify ways services can be improved

2 Method

2.1 Research Design

The study was devised using a qualitative approach. The idea was to conduct eight focus groups evenly spread across Kent composed of between three to five young people aged 15 to 19 years. The discussion was facilitated using a semi-structured interview guide, which was used by the researcher to elicit information from the looked-after young people (appendix 1). Focus groups were deemed the most appropriate way of working with this age group in order to deal sensitively with the issue of sexual health. Butler and Williamson (1994) have discussed the importance of using a flexible and adaptable approach when working with children in care. They suggest facilitating responses from young people through group 'management', as well as providing individual assurances, which they argued was an effective method when gathering qualitative data (Butler and Williamson 1994)

2.2 Sites and Sample Size

The research took place across Kent and focus groups were conducted within youth and community centres, as these were deemed more accessible to the young people. Some focus groups were conducted with young people who already met regularly as a group while others brought together individuals who had not had previous contact. It was hoped that the size of the target sample would total approximately 40-50 young people, however, due to access problems, the actual size of the sample was smaller and in all totalled 20 participants. A discussion of the problems with access follows below. The size of the eventual sample and the location of each focus group are given in table 1.

2.3 Access

This project benefited from the multi-agency advisory group set up to support the research programme as a whole, and members were able to supply the research team with a range of potential contacts to facilitate access to the target group of teenagers. We contacted numerous agencies that worked with looked-after young people including fostering agencies, educational networks, medical practitioners and young people's organisations. We found working with young people's organisations the most productive for generating interest and attracting participants for our study. These organisations in particular helped us set-up focus groups, as we were able to take advantage of a pre-existing network of young people's associations – these included Upfront and 16 +.

Table 1: Sites and Sample

Location	Size of Focus Group	Gender Composition		Ethnicity (2001 Census categories)		Age Ranges
		Males	Females	White British	BME[1] & White Other	
Canterbury and Coastal	3	1	2	3	0	17-19
Ashford	4	3	1	3	1	16-20
Ashford	5	3	2	4	1	16-17
Folkestone	3	2	1	2	1	16-18
Gravesend	2	0	2	1	1	15-19
Aylesham	3	0	3	3	0	17-18
Total	**20**	**9**	**11**	**16**	**4**	

Youth leaders were asked to approach young people to determine their interest in taking part, providing them with an information sheet (appendix 2). If they expressed an interest, the youth worker either arranged a focus group session directly or their contact details were passed to the researcher who then organised a session. The former route proved more successful. Consent was obtained at the point of the group interview, to ensure that the young people fully understood the nature of the discussion, issues of confidentiality and their rights of participation and withdrawal as laid out in the information sheet (see appendix 3 for consent form).

As stated, the actual number recruited of 20 fell short of the target number of 40-50. Recruitment with looked-after young people was very challenging. Both Heptinstall (2000) and Ward and Henderson (2003) documented the same problems, who found negotiating access with looked-after young people particularly problematic. We also encountered access problems with social service departments and foster care providers in terms of the time taken from the

[1] BME is an acronym used to refer to black and minority ethnic people.

first point of contact (from gaining official consent from managers) to actually setting up focus groups through care workers (Heptinstall 2000). A major reason for this was structural change within and across departments, also encountered by other researchers. Heptinstall for example discusses the ongoing structural changes within social service departments, which inhibited her access to recruiting looked-after young people (2000: 869).

We faced a similar issue in terms of staff restructuring, as changes in personnel and pending redundancies meant that some of our most resourceful contacts had been removed, and we found no other new points of contact to use to recruit participants. This bureaucratic obstruction was a factor in the challenge to recruit more respondents to our research, thus our overall number of participants was small. We were also aware that under-staffing meant that those professionals we dealt with were under considerable constraints of time. Research participation on any level becomes a low priority when professionals are faced with potential upheaval or redundancy. In addition to this, once the focus groups had been set up, the drop-out rate was high. Again, this is a common problem encountered with project recruitment among vulnerable groups, and was found in other parts of the programme (Billings and Macvarish 2007). However, despite this we were able to elicit rich data from those teenagers who took part.

2.4 Demographics

The geographical spread of the focus groups was dependent on the service structures and density of looked-after children in particular parts of Kent. Most of the county was relatively evenly represented, however, there were no groups conducted in South West Kent, although some young people in the Ashford group came from that area. The ethnic composition was drawn primarily from the 'White British' group (n = 16). The ethnic bias of our focus group participants is unsurprising in Kent, given that there are low numbers of minority ethnic groups across the county (3.5% or 54,957 of the total population who classified themselves belonging to black and minority ethnic groups/non-white) (Census 2001).

2.5 Data Collection and Analysis

Group interviews were conducted in community centres, usually in places where young people were already attending other organised sessions. On most occasions, professionals were not present during the groups as this was felt to have an inhibiting effect on the participants' responses. Private rooms were arranged where discussions using the semi-structured interview schedule were voice recorded. These were transcribed and analysed using a content analysis approach adopted by Flick (1998). Here, a template (supplied by the areas of questioning on the

interview schedule) was used to sort the data into themes. Data not fitting keenly into the themes was separated and also analysed thematically.

2.6 Ethical Issues

Ethical approval for this project and the wider programme of research was obtained from the East Kent Local Research Ethics Committee in 2004. There were a number of particular considerations to take into account (Thomas and O'Kane 1998) (Ward and Henderson 2003). Firstly, it was important to recruit young people through key workers who knew the teenagers, so that, given the varying literacy levels, details of the project and participation in it could be fully explained in ways that could be best understood. It was particularly important to ensure that issues of confidentiality were paramount, as many looked-after children have traumatic pasts which could have been revealed during the discussions. Leaders were ready to support teenagers if any distress had resulted from revelations. Participants were also made aware that they could have withdrawn from the project at any time, and this would not have altered their service support in any way.

3 Findings

This section reports the findings of the views and experiences of looked-after teenagers and is broadly separated into three main areas with sub-themes, as follows:

- Sex and Relationships Education
    - The timing of sex and relationships education
    - The content of sex and relationships education
    - The context of sex and relationships education

- Seeking advice about sex and relationships
    - Seeking advice from General Practice
    - Experiences of sexual health clinics: staff issues and access to services
    - Confidentiality and trust
    - Seeking advice from other sources: friends, foster parents and partners
    - The role of IT and other forms of dissemination
    - Knowledge and use of contraception

- Attitudes towards sex and relationships
    - Pregnancy and motherhood
    - Under-age sex
    - Alcohol use and sex
    - Attitudes towards contraception
    - Making connections: being 'looked-after'

3.1 Sex and Relationships Education

This section focuses upon the experiences of our sample regarding their sex and relationships education in school. It explores the timing of the lessons, experiences relating to the learning environment and how the education was delivered. In addition, a further sub-section draws together some underlying themes relating to interruptions and inconsistencies that help to explain the connection between their educational experiences and their status as looked-after teenagers.

3.1.1 The timing of sex and relationships education

The looked-after teenagers described at what age they first received sex and relationships education. In general they reported having first received SRE at school in about year six (aged 11), but had also received further information in secondary school:

> I remember it in year 6 at primary school before I left in year 7, and then in year 9 or 10 they taught us in secondary school…(Interview 6: 3)

Surprisingly, the young people at times expressed what might be construed as 'conservative' views about when they thought sexual health education should be provided. They believed that sex education should be given at secondary school and not any earlier, which perhaps differed from their own experiences, as many of them had received sex education whilst at primary school:

> I think once you turn 13, I think 11 is far too young, I think once you turn 13 and you turn a teenager, I think that's when they should start teaching you, because I mean 14, 15 when people start to have like kids and things like that, so I think 13's the age were they should start, laying it on heavy (Interview 1: 3)

> I reckon it should be like in the start of secondary school, not in primary school because that's just wrong
> (Interview 4:13)

In only one case did a young person suggest children were never too young to receive information on sexual health,

> At the end of the day I don't reckon it's too young to start telling your kids about sex education because at the moment you've got like parents that are sort of 13 years old in any case. (Interview 2: 7)

In terms of timing, most felt that sex education needed to be provided more than once and perhaps as part of their school curriculum:

> It should be regular. (Interview 4: 13)

> I think it should be all tied in together, say like you know they do it every so often as a lesson. You know? (Interview 4 :13)

Only one young person said that they had received sexual health education as part of their weekly curricular activity:

> …but we watched different ones [videos] every Friday. Like sometimes we would read a book or talk about it. (Interview 3: 13)

3.1.2 The content of sex and relationships education

Respondents gave some insight into their learning experiences, particularly in relation to strategies employed to assist with learning and issues related to the school environment within which the learning took place.

With reference firstly to strategies, of interest was the fact that young people in the study appeared to have strong recall of methods that used powerful images, for example, showing photographs of STI symptoms. These comments show how images of sexually transmitted infections were imprinted on memories:

> When I went to college they really laid it on about STIs, they showed us pictures…we were shown horrific pictures of all different stuff and that was like, that was actually quite useful
> (Interview 1: 3)

> You should say to girls this is what might happen if you end up sleeping with someone without no protection. (Interview 2: 17)

Other respondents reported approval of the use of 'cyber-babies' with both males and females in order to show how difficult it was to take care of a child:

> … they should do it for everyone in the school so they know how it feels. What's it going to be like when you have a baby? If you're thinking about getting pregnant they'll forget about it straightaway.
> (Interview 6: 22)

Other visual and practical methods were recalled and recommended;

> There was this long thing, long thin thing and it was plastic and they sent it around and you had to put a condom on it
> (Interview 4: 2)

> Illustrations should be used as well, not videos, but like leaflets and stuff…
> (Female, Interview 1: 3)

The use of sexual health videos was not seen as particularly useful as the above quote implies, perhaps because of they were associated with poor teaching of SRE, where watching a video was substituted for active and engaging lessons.

> It was just in the library. They just plonked us in front of the TV and said watch TV
> (Interview 3: 9)

3.1.3 The context of sex and relationships education

It is widely recognised that looked-after children are at increased risk of disruptions to their schooling (Polnay and Ward 2000), combined with the potential for greater than normal disillusionment and disengagement from the education process. We found that the looked-after young people had often missed out on sex and relationships education altogether, because they had either moved school or had not attended school at all:

> I didn't do sex education at school…Because I was moving from school to school
> (Interview 2: 2)

> I didn't go to school. No I did. I went to primary school. They didn't do sex education in primary school actually. In secondary school I went for the first year, year 7 and 8 and then the other 3 years I didn't do [it]
> (Interview 6: 4)

Inconsistency in the teaching of SRE had particular implications for children whose school attendance was disrupted. The following quotes give an indication of the lack of sex and relationships education they received;

> No it was only one… They only came in actually one day and in so many hours they were going around the lessons
> (Interview 4: 7)

> And we only had one lesson. There were both classes, about 60 of us squeezed into one room and everyone talking
> (Interview 3: 5)

For these teenagers, it is hardly surprising that a connection was made between the lack of education and the quality of information. When it was received, it was seen as gravely inadequate:

> They only came in once and it was like… you know they sit there trying to cram in everything in one and then it just gets really boring because you can't understand what they're saying
> (Interview 4: 20)

One young person commented that looked-after young people always felt estranged and therefore never settled into their schools. She said "when we're at school we got treated different" (Interview 6:10). Her comment is a rather sorrowful reminder of how marginalised and unsettled these teenagers can feel and that they do not feel that school is a supportive place for them to learn. It is perhaps not surprising then that our respondents felt that school was the least appropriate place for them to learn about sex and relationships. The potential for discomfort seemed to be key. For example, one person stated that this subject was the cause of great embarrassment to young people and as a consequence they could not take sex education seriously:

> …no-one listens when you're at school because they just laugh about it…They just think it's funny though. I used to when I was at school, do you know what I mean? (Interview 6: 6)

Like the school students surveyed and the teenage parents interviewed, the looked-after children argued that a major cause of embarrassment was mixed gender teaching of SRE.

> In secondary school I don't think it works because they mix the boys and girls together and the boys always seems to be a little bit immaturer than the girls. No offence boys. It was always them talking. (Interview 3: 11)

Perhaps as a result of these experiences there was a view that changing the learning environment to one that was outside of school would encourage greater interest. This respondent suggests that schools could play a role in familiarising young people with local sexual health services:

> I think schools actually should go out to a special clinic and just give them a tour of that place. That's what I would say would improve it.
> (Interview 2: 20)

It was clear during the discussions that looked-after teenagers preferred outside speakers to talk about sexual health rather than their school teachers, suggesting that they would not take the information seriously from teachers:

> …someone independent, not a teacher because you'd sit there p***ing yourself laughing all day wouldn't you?
> (Interview 1: 3)

Other young people also indicated a specific preference for external sexual health and relationship advisers, perhaps through their own experiences of having contact with them:

> Social workers. They should be really…a person, one single person or a team of single people that are trained in that area
> (Interview 2: 22)

> You should have a group of people that are specialised in that and you can send them around Kent and like make a little drop-in…Like drop in centres. You know like we have drop-ins, basically so that everyone can attend it
> (Interview 2: 22)

The respondent below builds on the above sentiments by expressing the value of using health care professionals to provide education and access to contraception, and the benefits to young people when schools endorse and support these strategies. This young person acknowledged

that her school took sex education very seriously and was willing to support this work by providing additional resources and time to spend with pupils to help them learn about sexual health. Young people could also feel reassured that they could approach health professionals in confidence without the information being passed onto their parents.

> Yeah they sort of really like demonstrated, and we also had a little room in our school which was for like talking to erm, like a health person, she could also give out condoms and things, they used to have a massive stock of them in this drawer and at my school you used to be able to go in and talk to them and like get condoms or they would talk to you about going down to the family planning clinic and your parents not knowing about you going on the pill and things like that, because if they were under 16 and they didn't want their parents to know (Interview 1: 5)

3.1.4 Commentary: Sex and Relationships Education

In summary, while there was general agreement among the respondents about the need for sex and relationships education, some comments revealed quite 'conservative' views and the teenagers seemed to be concerned about younger children having too much knowledge. This finding was also apparent in the school survey, when a fifth of pupils felt that children were given sex education too early. These responses can be read in a number of ways. The most straightforward interpretation is that the young people thought that sex education was most beneficial at the point when it was most relevant – at an age when young people are more likely to be engaging in sexual experimentation and information becomes a practical necessity. Another reading is that the respondents could be expressing a desire for greater clarity and control in the boundaries established by adults in relation to teenage sexual activity. Equally, they could have absorbed and internalised societal discourse about a 'moral decline' which is often culturally disseminated in terms of young people's sexual activity, a message which may also be reinforced in health promotion messages aimed at young people emphasising the risks of STIs and pregnancy. The view that 'things are getting worse' when it comes to young people's sexual behaviour was also expressed in our study of teenage parents (Billings and Macvarish, 2007) and was interpreted as a means by which teenage parents could distance themselves from the 'even worse' cohorts coming after them, indicating the acceptance of wider societal disapproval of teenage sexual experimentation.

Other findings also mirror the survey results and teenage parent interviews. It does seem to be the case that the handling of potentially embarrassing subjects in large mixed classes continues

to have a negative impact on the learning experience and needs to be addressed more sensitively and creatively. For looked-after young people who may have more tenuous relationships with school colleagues and who may already feel isolated and exposed as different, the potential for embarrassment is maximised. Issues are also raised by the increased likelihood of looked-after children having been subjected to sexual abuse. Opportunities for one-to-one consultations with sympathetic and knowledgeable adults were particularly highly valued by the looked-after sample, who, like many of the teenage parents, were often disengaged from school and distrustful of regular teaching staff. Concerns about confidentiality were particular significant in a context where friendships with other pupils may have been weak and questions of adult responsibility were sometimes unclear. Comments from this section start to illuminate the realities of life as a looked-after teenager in the context of their education.

In terms of information provided from schools, what is apparent from their accounts is that schools have been unable to ascertain what level of sexual health information transient young people have had in the past and what new information they need to know. As a result, what is provided tends to be disparate levels of 'catch-all' sex education to an often wary and disengaged audience. It was unsurprising therefore that respondents spoke about how little sexual health information they had received at school and were critical of the learning methods that were used to impart it. Others commented that they had not received sexual health information at all whilst at school, some because they had missed out due to non-attendance. The concomitant disruption to school-based sex education has also been noted in previous research (SCIE 2005), making it essential that alternative sources of information and support are made available to looked-after children. Williams et al's (2001) study exploring the health of young people in local authority care came across the same problem; this group received significantly less advice about contraception and less information overall about heath promotion (Williams, Jackson et al. 2001).

Attempts to capture interest by using arresting images, practical activities and teaching aids seem to be effective in facilitating recall, and the survey of Kent school students and the study of young parents support the role of teaching aids and engaging illustrations in the recall of SRE information. However, studies have not confirmed the effectiveness of tools such as cyber-babies in changing teenage sexual behaviour and academics and health researchers have questioned the negative framing of teenage sex in the 'health risk' approach to teaching SRE (Woodcock, Stenner et al. 1992; Oakley, Fullerton et al. 1995; Wight, Raab et al. 2002). Ott et al (2006) explored the positive motivations for sexual activity professed by young adolescents, such as developing intimacy, improving social skills and experiencing sexual pleasure. Lewis and

Knijn (2001) also challenged the overwhelmingly negative focus of English sex education and questioned the focus on self-esteem, contrasting it to teaching in the Netherlands, where the emphasis is on self-reliance and relationships rather than the self, and contextualizes sex as a normal, positive development within relationships. The emphasis on delaying first sex or on casting sex as an activity associated only with negative consequences runs the risk of reinforcing rather than diminishing young people's fears of being judged if they seek advice from professionals. Being labelled or seeing themselves as careless or stupid for engaging in sexual experimentation may understandably make young people less willing to confide in adults when help is needed, whether that is parents, carers, teachers or health professionals. For looked-after children, who may already be aware that they are labelled as 'problematic' and prone to social and educational failure, the potential for embarrassment and inhibition is potentially increased.

With reference to the findings in the survey, there appeared to be a contrast between the school experiences of young people living with their parents and young people living in care, with survey respondents more trusting and confident of their teachers. The apparent lower levels of confidence and trust that the looked-after teenagers had in their teachers could have stemmed not only from the experiences of sex education delivery, but also the fragile relationship consequent to interruptions and movement in their schooling. However their greater levels of confidence and trust in external providers of sex and relationships education may also reflect their own experiences of encountering practitioners who work in the health and social care profession, which was perhaps not the case among the survey respondents. This issue of trust is explored further in the next section.

3.2 Seeking Advice about Sex and Relationships

Given the challenges to receiving sex and relationships education in the school environment, this section concentrates on other sources that our respondents used to seek information. It explores experiences and views of seeking advice within General Practice, from sexual health clinics, amongst friends and family, as well as looking at the use of the internet. Additionally, we report on knowledge levels of contraception, attempting to reveal the extent to which current methods of education and information sources have equipped our sample with the knowledge they need. Finally the undercurrent of mistrust is once more brought to the fore here, as we gain further insight into the difficulties looked-after teenagers have in dealing with professionals.

3.2.1 Seeking advice from General Practice

The young people spoke about approaching doctors and nurses at their General Practices for advice and information about sexual health matters. The following comments indicate mixed views about such consultations. These initial quotes illustrate a potential and actual willingness to consult their doctors for advice:

> …the Doctor could be better because it's more personal because you share it with the Doctor
> (Interview 1: 6)

> Because they understand more… I went to the Doctors and that's where I get the advice
> (Interview 1: 6 & 7)

However, this was the minority view, and most spoke at length about how unwilling they were to approach their doctors; the following quote is a typical response:

> It's got nothing to do with the fact of being embarrassed because I've got no problem about speaking about that at all, but at the end of the day I would not speak to a doctor about it because they talk to us completely different…
> (Interview 2: 15)

Other studies have found that looked-after children are more likely to have transient relationships with General Practitioners (Williams, Jackson et al. 2001), making it less likely that relationships of trust can be established with a 'family' doctor.

A gender issue arose. Two of the young people talked about how they preferred consulting female doctors and nurses, but felt uncomfortable asking male doctors for advice:

> I won't go to doctors. I'll go to nurses but I won't go to doctors… Or women doctors I'll go to
> (Interview 4: 14)

> You see me I feel more comfortable talking to a female than I do to a male … you probably get really embarrassed to talk about things that you normally

> wouldn't talk to a male with. And if you're talking to a girl… most girls are more… pay more attention than males do
> (Interview 2: 36)

These quotes hint at discomfort and embarrassment, and lack of faith in male health care professionals to understand female health issues. Among our sample there were other reasons why female professionals were preferred, relating to accessibility and approachability:

> Nurses are alright as well, for things like that, you can get to them quicker as well
> (Interview 1: 8)

> Because like there was this woman there who I used to have as sort of like a school nurse and I talked to her all the time and she was down there so I was talking to her about it
> (Interview 4: 9)

As noted early, looked-after children may in fact be more accustomed to speaking to professionals outside the family than children living with their parents, and may therefore be well able to make use of regular relationships with health professionals who are consistent in their lives and prove themselves to be trustworthy.

3.2.2 Experiences of sexual health clinics: staff issues and access to services

When discussing their views and knowledge of using sexual health clinics, the looked-after teenagers reported a variety of experiences and opinions about such services. The importance of having friendly, supportive and approachable members of staff seemed to be highly influential in determining use. Some young people spoke of positive experiences of using sexual health clinics. They reported having used the clinics for obtaining information, the morning after pill, the contraceptive pill, implants and condoms:

> It was alright. They were quite friendly down there…Yeah. I've been there a few times and got them from the machines and things like that
> (Interview 4: 11)

> Family planning clinics? They're really good actually. They talk about the coil, about the arm thing, the implant… (Interview 6 :8)

However, other young people spoke of challenging and negative encounters with these services that had the potential to act as a deterrent:

> Sometimes they can be a bit arsey. Like AGAIN, you know or something, my friend went for the morning after pill and things like that, they're like 'again?', you know. You feel uncomfortable, they keep you waiting ages
> (Interview 1: 11)

> Now we walked in there with her and her boyfriend and at the end of the day my sister stormed out because they weren't actually listening to what she was saying. They were sort of trying to feed a load of things into her head, like saying well you should sort of prepare for this and all of that…
> (Interview 2: 16)

> Unfriendly staff, you just don't want to go somewhere like that, and they're really stressy or off with you or… you're already nervous enough going there, you need them to be a bit supportive as well.
> (Interview 1: 7)

Drawing from their views, although in some cases it was clear that they had not received the advice they sought, more importantly they had not been treated in a manner acceptable to them. These comments show that our respondents have far greater concern of being treated unfairly and being judged, of not being listened to or not being given support, and on the contrary being given what they regarded as unnecessary advice and information.

With respect to other staff characteristics, the opinions of the young people appeared to differ over the age and gender of the practitioners at sexual health clinics as these quotes imply:

> I think they should be older…Yeah. Because then they've had a lot more experience haven't they?
> (Interview 4: 16

> …it doesn't really bother me what sex they [the staff] are, but I mean it depends how old they are if they're like about 70 I wouldn't like to talking to somebody like that (laughter) I'd feel well uncomfortable, they're not meant to be having sex at that age! (Female, Interview 1 :7)

In the study of teenage parents, the age of health professionals was significant in that older people were assumed to be more judgemental and disapproving than younger people. Sometimes this was a question actual age, but often 'age' was actually a question of attitude, so an older practitioner who was judged to be friendly and sympathetic could be described as being 'young'. The presumption of judgement and disapproval is a very significant influence on young people's preparedness to access sexual health services.

Knowledge of how to access sexual health clinics was variable. While some had no knowledge, others were more informed about opening times and locations. However, there were clear indications of access difficulties:

> The opening times for family planning is about 3-5pm. There's a walk-in centre 6-8pm but like… I missed an appointment once because the walk- in centre was closed.
> (Interview 4: 16)

One young person mentioned that access for school-age students was difficult, because the centres were open during hours when they were at school:

> It is easy to get to but the times aren't right and it's all spaced out. There's one in ***** (location) There's one in *****. There's one in *****. Where else is there?…But all the times aren't right because the people are at school and by the time they come out of school they've only got like an hour to get there and it could be closed by the time they get there
> (Interview 6: 21)

There seemed to be some astonishment that the opening times were unsuitable for them which meant that they were unable to visit the clinics. They commented at length about this and suggested that opening and closing times should be extended to accommodate their needs:

> I reckon they should do it during lunchtimes, like from… you know, in the school or they should have like one person go in the school
> (Interview 4: 17)

> Kids come out from school at like 3.30 say 4 o'clock. So if you did, say for instance from 6-8.30 that would be good (Interview 6 :8)

The school survey and teenage parents study found little consensus on the most appropriate opening times for sexual health clinics. Accessibility depended on the amount of freedom, money and transport links available to young people. Similarly, while some young people favoured the privacy of accessing clinics away from school, others valued the convenience of on-site contraceptive services.

3.2.3 Confidentiality and trust

Trust seemed to be an important underpinning value in the belief systems of our sample, as indicated in previous sections. Here, trust was linked to confidentiality during the discussions about contact with health care systems. Thus when speaking of their contact with staff, they stressed that health professionals in particular should uphold confidentiality as this strengthens trust:

> If you don't have confidentiality you're not gonna go and say… If you go to a clinic and you say something and they ring up your parents, that's it, you're not gonna go again, ever…
> (Interview 3: 18)

Despite the fact that there were generally strong views about upholding confidentiality especially from parents and carers, some recognised that there could be situations when it would be necessary for parents to be consulted. Both comments below relate to underage sex:

> If something's that serious. I thought they should [parents] have been told. She was only like 15, 14 or 15…
> (Interview 3: 19)

> That's wrong. I think they should be told. I think… If the child is like 15 that's still counted as a child. Parents should be told I think
> (Interview 3: 19)

However, the general undercurrent of trust and confidence in professionals previously hinted at, rose to the fore in this theme, as teenagers spoke about a general lack of trust and had fears about issues of confidentially.

3.2.4 Seeking advice from other sources: friends, foster parents and partners

Friends

It was of interest that, more often than not, the young people commented that they would rarely seek advice on sex and relationships information from their friends. The predominant reason was embarrassment; the female participants here talked about how they would feel if they brought up these subjects:

> …I probably wouldn't speak to my friends so much because you just get to that stage when they think it's all hilarious or you know. I don't know, I don't think I'd speak to my friends…
> (Female, Interview 1: 12)

> No. It's not an easy thing to bring up is it really with your mates. Girls don't really talk about things like that. We just talk about girly stuff
> (Female, Interview 6: 17)

This finding runs counter to the school survey, where a large percentage of respondents cited friends as sources of information. Other looked-after teenagers felt that they could not consult friends on contraception and pregnancy advice, because they were not seen as reliable sources of information. Surprisingly, it may have been expected that they confided in each other, because they had no other support from their own families. However, clearly among our respondents at least, this was not the case and they did not want to talk to their friends. The teenage parents studied were found to value maternal and professional advice and support more highly than that of their friends, which may suggest that when faced with real, 'adult' problems, teenage friendships are not regarded as sufficiently reliable. However, the degree of dependence revealed by many of the teenagers on their parents, especially their mothers, in the survey and the young parents study further emphasises the need for looked-after children to have access to alternative sources of consistent and sympathetic adult care.

Foster Parents

Although the young people felt unable to talk to their friends, they did feel that they could approach their foster parents about seeking sexual health information and relationships advice. Foster parents were the most important adult figures that some of the young people said they would speak to:

> I've been there [with current foster carers] only about 14 weeks, but they're well nice, they're proper laid back, they never get in my way at all, they don't ask me, if I want to talk to them about something then they'll listen, they'll be there for me to listen but they wouldn't ask me any questions like about sex or anything, if I want to talk to her about it she's always there for me
> (Interview 1: 12)

> My [foster] mum knows exactly what I've been up to. Even if I haven't wanted to tell her she's been really supportive and kind of positive about it and she knows everything I've been up to and she knows my ideas.
> (Interview 3: 17)

> Because I had to go on the pill and that. Like, you know, they mentioned it so I went on the pill and then I was talking to her about it and she said go to the clinic and like have the injection so…Well she said to me go down there and ask them about it because she didn't… you know she knew about it but not… because she's had girls there before talking about it so…
> (Interview 4: 9)

The relationship between looked-after young people and their foster parents is a unique one, which bridges both the private and public realms in social relationships. Thus, the ease with which these young people were able to talk to foster parents was clear, perhaps due to a greater sense of trust in them, and a recognition that foster parents have the experience and skills to give them sound emotional support. This may also have been enhanced by the diminished sense of connection with their birth parents. One young person in fact spoke about how they preferred to talk to their foster mother rather than their own birth mother about sexual health and relationships advice:

> I could talk to my foster carer about that though because she's like my mum. I couldn't talk to my mum like it though. It's a difference…
> (Interview 6: 12)

Only one teenager explicitly said that they would not talk to her foster parents, because she was afraid of a breach in confidentiality, highlighting the difficulties that some looked-after young people have in establishing any trusting relationship:

> But I wouldn't want like my foster parents to know. Say if there was something private I wouldn't want them to know…I would get worried if it was like say my foster parents or something like that. They'd ask questions and… But at the end of the day I wouldn't really… I shouldn't be bothered because I would just tell them it's my business
> (Interview 4: 15-16)

In contrast to our general findings, Wilding and Barton (2003) found that looked-after young people did not feel that foster carers had the responsibility or the time to be involved in providing sex education to young people in their care. The difference may be due to a linguistic distinction between formally delivering sex education and being able to talk frankly with foster carers about sexual health issues. Our teenagers' responses indicate strongly that where a relationship of trust was established with their foster parent, they did consider it possible to confide and gain advice. At a local level this may be connected to foster carers' growing confidence in addressing relationship and sexual health issues as a result of the development of the Kent multi-agency RSE Policy for Looked After Children and Young People. This policy with its accompanying RSE training 'Great Expectation' was developed to support the role and has been widely attended by foster carers across the county.

Between Partners

With respect to discussing sex and relationships with partners, teenagers tended to describe how free and willing they felt within a relationship to talk about such issues:

> I don't know, I just think that's a decision that needs, between you and your partner it's your bodies you know, I don't think you'd want every Tom, Dick and Harry needs to know.
> (Interview 1: 15)

> We've discussed this already, like me and my girlfriend. So at the end of the day she has turned around and said she would rather go on the pill than risk the fact of the condom snapping. So at the end of the day she's choosing the right thing to do about it.
> (Interview 2: 6)

3.2.5 The role of information technology and other forms of dissemination

The looked-after young people did not find any of the newer sources of sexual health information very useful. They commented on using information cards, free-phone numbers and accessing the internet. The teenagers did not think that the free-phone numbers were of any use because they were not free to call from a mobile phone:

> You see on here it says…telephone number but it's not…it can't be accessed by a mobile phone…They charge you. I think the number should be changed so that any phone can be able to call it …
> (Interview 2: 29)

Private access to landlines was clearly restricted, with their mobile phones being a more appropriate method of communication. For similar reasons, the young people had limited private access to the internet whether at home or at college.

> At college?…A lot of the times you don't really want to go on the computer because there are lots of people around and you don't want to start typing this number and people are watching what you're doing…
> (Interview 2: 31)

This indicates that although service providers have identified new technology as a means of making contact with young people, in reality, the degree to which young people can make use of such innovations is limited.

3.2.6 Knowledge and use of contraception

Given the varying educational experiences and difficulties accessing and using services, it was important to try to identify themes in the data connected to understanding of contraception and knowledge levels. The looked-after young people's knowledge of contraception was, in line with other young people, primarily limited to the Pill and condoms. This respondent was aware of the limitations of the information conveyed to young people.

> There's such a wide choice and you get taught about condoms and pills. That's it basically
> (Interview 3: 21)

Unsurprisingly given the narrow contraceptive options presented to young people, and in accord with the teenage parents study, there was some confusion about the nature of emergency contraception and confusion between the 'morning-after Pill' and abortion. One young woman talked about not using the morning-after Pill, because she thought that it entailed killing a formed foetus:

> No I wouldn't do that because if the foetus is formed then you've killed the foetus
> (Interview 6: 16)

Some of the other young people were conscious that the forms of contraception most readily available to them were not necessarily fool-proof:

> All it's meant to do is help prevent it [pregnancy]…They still suggest you to use condoms. And now even in doctors now when you go with your girlfriend they will turn around and say at the end of it they will try and advise you not to use condoms and they will try and advise the girl to actually start going on the pill or something to do with that. At the end of the day the only reason why is because the condom isn't 100% safe
> (Interview 2: 5)

> Condoms can prevent sexually transmitted disease and the pill can actually stop pregnancy a lot better than condoms
> (Interview 2: 40)

The young people above had clearly taken on board health messages that condoms or the pill alone could not guarantee protection from STIs and pregnancy. With respect to actually obtaining contraception, the sample appeared to have varying experiences and preferences. The teenagers knew where to obtain condoms outside of sexual health clinics and were aware that they could purchase them from vending machines, supermarkets, pharmacists and from college:

> You can get them [condoms] in pubs
> (Interview 1: 9)

> If you want to buy them, I mean in Canterbury there's so many places, I think the college give them out as well, our college, our student union give them out (Interview 1: 10)

> …but if you go to…up town or in the supermarket you get condoms from there (Interview 3 :10)

It is noteworthy that some young people appeared to have a preference for obtaining contraception from away from sexual health clinics and without having to consult health practitioners:

> Now you just walk in and buy the stuff and walk straight back out, you ain't got to say nothing but to talk to a doctor about it is quite embarrassing to sit there and say to him well can you sort of check me over for all of this or whatever and you don't really want to be sitting there talking to the doctor
> (Interview 2: 35)

The comment above shows that the young person preferred to purchase condoms from commercial suppliers, because they felt they had a much greater degree of anonymity and less 'personal interference'. However, another young person felt embarrassed about purchasing condoms for fear of being judged:

> You know when you go into Boots or Superdrugs to get condoms, you get these flipping weird looks from the cashiers saying oh what are you up to then?...Yeah but then again my nan could walk down the aisle and she could pick them up and not one person would stand there and look at her about it and I think that's wrong
> (Interview 2: 37)

This teenager argued that he felt the cashiers were passing judgement on him for engaging in sexual activity. This suggests that despite their knowledge and awareness of where contraception is available, there may still be significant barriers which inhibit young people from buying or getting free condoms.

3.2.7 Commentary: Seeking advice about sex and relationships

In summary, although some of the respondents had received some helpful advice from General Practice and sexual health services, issues relating to embarrassment, styles of communication, gender, and expectations of judgement and disapproval clearly impacted upon the decisions of most of our respondents to use these services. Thus, the young people showed a preference for consulting female doctors and nurses, and male doctors were seen less favourably and perhaps less likely to be consulted about sexual health matters. In their examination of staffing at contraceptive services for adolescents in the United States, Philliber and Jones (1982) have suggested that young people, especially females, preferred consulting female counsellors in matters concerning a 'personal' nature. They indicated that the adolescents displayed a preference for female councillors, "who possess[ed] stereotypic feminine traits, such as warmth and understanding" (Philliber and Jones 1982). Philliber and Jones's argument supports the finding shown in this study – that looked-after young people feel at ease when talking to female health and medical practitioners regarding sexual health issues.

The looked-after teenagers reported countervailing views of their experiences of using sexual health clinics, highlighting both positive and negative experiences. Some young people talked about being treated unfairly and being judged, feeling their wishes and needs had been ignored. Others believed that they could seek advice on a variety of issues such as contraception, abortion and sexual health. Respondents held differing opinions on whether they found the staff approachable, but the anticipation and actual experience of negative attitudes had the potential to act as a deterrent. The issue of young people's fears of disapproval or embarrassment should be taken seriously as they may make them reluctant to seek help at an early stage. Mellanby, Pearson et al point out that even exemplary services are intrinsically alien to young teenagers' sensibilities (Mellanby, Pearson et al. 1997). However, the same researchers found that that young people's anxieties about accessing services are alleviated by actual experience of use. Despite their reservations, our respondents saw these clinics as an important source of information, in particular, they were favoured above school-based sources of information.

Other barriers to attendance at sexual health clinics were hours of opening. These findings largely mirror those of the school survey, where a large percentage of freehand comments remarked upon difficulties with access to clinics. Suggestions for improvement included opening clinics during school lunch-hours and for a few hours after school in the afternoon, as well as bringing contraceptive services into the school on a regular basis and familiarising pupils with clinics in their locality.

It was of interest that the respondents felt unable to seek sex and relationships information from friends, but this again may be due to their transient nature if friendships are frequently disrupted. Foster mothers however were seen as the first person the teenagers felt they could speak to, related in part to an acknowledgement of skills and experience, but also to the trust that had developed between child and adult.

It is important to note that the young people faced significant barriers to accessing information via the internet and were reluctant to use phonelines which incurred a fee when accessed from a mobile phone. Internet access was restricted and rarely took place in private, ruling out its potential as a source of confidential information for young people.

The young people were fairly knowledgeable about contraception but this was restricted to condoms and hormonal contraceptives and where to access them. However, this knowledge varied greatly between individuals and may have been more concrete amongst those who were sexually active. Our study did not elicit information about the young people's sexual activity, but given the age-range of the sample (15-20), we can assume that a significant number would have been sexually experienced.

3.3 Attitudes towards Sex and Relationships

This section pulls together some themes that became evident when discussing the main topics, and revealed some interesting attitudes towards pregnancy and motherhood, under-age sex, alcohol use and sex, and contraception. In addition, the last sub-section makes connections between the themes and explores the lived experience of being looked-after in relation to disruption, attachment and emotional feelings.

3.3.1 Pregnancy and Motherhood

A number of the looked-after young people were disapproving of young parenthood.

> …there was a programme on last night, did you watch it? (yeah) Did it not emphasise the fact that if you got pregnant and then in two years time everything would be fine?…Yeah but it's like you struggle at the beginning and then everything's fine, I really thought it emphasised the fact that, yeah get pregnant at that age you know and you'll be fine
> (Interview 1: 16)

She was suggesting that such documentaries show that teenage motherhood is not as difficult as one would first believe and that in fact teenage mothers can cope. This young person found this view untenable and was alluding to the idea that such programmes promoted the idea of continuing with the pregnancy. Another young person confirmed this perspective by drawing from the actions and decisions made by one of her own friends who had become pregnant:

> …one of my friends deliberately got pregnant. Some people just want to have babies, don't they?
> (Interview 1: 16)

A more critical view of teenage mothers was articulated in another focus group:

> They don't think about it. I mean they just want an escape. You know they're like oh we'll get a house, you know, if we have a baby or things like that…Some of them have got pregnant and they're just like oh I wish I'd never done it or… You know? Or sometimes they're like oh I wanted a baby but they didn't and things like that
> (Interview 4: 18-19)

Although this perspective draws directly from some of the widely held views projected in the media that teenage mothers became pregnant in order to gain housing and welfare benefits, there is also a sense held in common with the previous comments, that young parenthood will be regretted because it's difficulty is greater than anticipated. Rather than a moral objection, this is a pragmatic rejection of young parenthood.

3.3.2 Under-age sex

In addition to prevalent disapproval of teenage parenthood, the sample demonstrated similar concerns about under-age sex. They felt especially protective towards younger siblings and thought that as future parents, they would constrain the sexual behaviour of their offspring:

> If my brother come round, come and told me yeah I had sex last night and he was like 12 I'd kill the girl and I'd kill him an' all. I don't agree with that and I don't think I could cope with something like that, I don't think I'd agree with anything like that either.
> (Interview 1: 17-18)

However, others thought that maintaining open communication between parent and child was more important than expressing disapproval.

> I'd rather my kids tell me that they were having sex so that I can help them like say put them on the pill or something, I'd rather them not just fall pregnant and then come into me and say Mum I'm pregnant
> (Interview 1: 17)

Another young person had observed that she felt that her friends were too young and not sufficiently knowledgeable about sex to deal sensibly with a sexual relationship:

> From the people I hang around with and my friends and my experiences most people that have sex are still too I and not immature as in just kind of silly immature but just not mature enough to have sex and then they say they regret it afterwards as well. But it's hard to gauge if you're ready before or not, especially if you're pressured.
> (Interview 3: 20)

The statements above suggest that young people have their own concerns about teenage sex and its potential consequences. Here their views are similar to those widely expressed but more usually associated with adults. It could be argued that although looked-after young people are more likely to become teenage parents than children living at home, they may also be more aware of the difficulties of parenting from their experiences of their own parents' problems.

3.3.3 Links between Alcohol use and Sex

The data collected on this subject was quite minimal, but some interesting themes arose. Those commenting on this subject were aware of the links between alcohol use and pregnancy. One young person said that they had engaged in sexual activity having been drunk, which led to some unforeseen consequences:

> We were both absolutely slaughtered that night. And then 2 months later I found out I was pregnant
> (Interview 2: 10)

Others were conscious of being targeted when going out socially for drinks, thus felt vulnerable.

> If I've got a drink I won't let it go. Even if you see your friends…because if you're in a bar you don't…If I know I've left my drink or if I've gone to the bar I won't drink it
> (Interview 3: 24)

They thought that they were sufficiently knowledgeable to deal with this problem and talked about using stoppers to prevent their drinks from being contaminated and paper tests to find out whether their drinks had been spiked:

> Yeah you can get little stoppers as well to put in your bottles
> (Interview 3: 25)

3.3.4 Attitudes towards contraception

The looked-after teenagers were asked what advice they would give to other young people who were sexually active. They talked mainly about using condoms reflecting the health messages they had been exposed to and perhaps the limited scope of their experience:

> Just always use a condom. Yeah protect yourself.
> (Interview 1: 17)

> Wear a condom
> (Interview 3: 25)

> Wear a condom. Wear a condom.
> (Interview 4: 20)

> Wear a condom or take the pill or do whatever…
> (Interview 6: 18)

As the statements above show the looked-after young people knew most of all about condom usage. It seems that they felt using condoms was the most secure and the most accessible contraceptive and perhaps reflecting a sense that this would protect them from pregnancy and STIs.

Two of the young women who had recently become mothers promoted using other forms of contraception. One, commented, "…have the injection" (Interview 6: 18).

During this particular focus group one young woman stated that condoms were not the most reliable form of contraception, because in some situations, engaging in sexual activity was not planned and condoms were not always to hand.

> When we ran out [of condoms]…But then we got bored and we just didn't use them (Interview 6: 6).

This comment suggests that for some young people, maintaining the motivation to use contraception effectively does not come easily. Such statements were not common amongst the comments of the other young people we spoke to, however, it may be that there is a gap between what teenagers think is the right thing to say and what happens in practice; the teenage mothers may have been more frank because they were reflecting on past behaviour whereas the other looked-after young people may have been keen to impress that they had absorbed sexual health messages. Amongst the sample as a whole, both males and females felt that using contraception was a responsibility that lay with both genders:

> Both should be responsible, because no matter what…he might forget and if she's got condoms…
> (Interview 2: 38)

The majority of opinions showed that young people were able to talk in terms of taking responsibility for their actions. They had thought about contraception usage and said that they did not rely upon their partners to take precautions. One young person talked thoughtfully about being sensible and about making their own decisions. She said, "I think it's just thinking. You've got to think for yourself" (Interview 3: 25). This young person was suggesting that it was important to think carefully before engaging in any sexual activity and not to feel pressurised in a situation that they were not happy with.

3.3.5 Making connections: being 'looked-after'

Moving from pillar to post

The young people talked extensively about being moved through countless foster families and foster homes. They were aware that they had been moved 'from pillar to post', which was a sentiment that was echoed by them many times over. One young person commented that, "Social workers just come and go like grasshoppers" (Interview 6: 10), which shows that the young people felt that they did not have any adult figure to confide in and talk to and that

relationships were transient and not worth investing in. Unsurprisingly, the looked-after young people commented that they felt alone sometimes and had no support from their care workers.

Some felt let down by their own parents, but also commented that the foster care system had failed them too. This quote expresses the emotional consequences of the constant movement:

> Yeah it is really hard because we don't feel like we're loved and like we're accepted. We feel like we're really pushed out to the side because everybody else is more important than us because we didn't have our mums or dads or our aunties or our families and we got someone else. But yeah I think we take it different to the others
> (Interview 6: 10)

> It's half and half on that one because of what we've been through it's very hard for us to trust other people if you get what I mean. I don't trust no-one.
> (Interview 6: 14)

As well as the absence of trusted adults in whom to confide and who could help in problem-solving, they also expressed the view that looked-after children are particularly vulnerable to pregnancy, because their home life had been so disrupted:

> Loads of people out there yeah do get pregnant under age. Yeah, because sometimes like people in foster care…How many people are pregnant in foster care…Because they have been moved from pillar to post.
> (Interview 2: 10)

The feeling of rejection by their birth parents and the failure of the foster care system had impacted upon some of the looked-after young mothers' decisions to continue with their pregnancies. One young woman spoke of how, after becoming pregnant, her birth mother wanted to re-establish a relationship with her, therefore she continued with the pregnancy and moved back into the family home, but the situation was unstable.

> I know we're not really meant to be speaking about our family and all that yeah but my mum rung me up out of the blue one day when I was at college and I met her that day… Because my social worker rung her up and said that I was pregnant… And I moved home with her for about 3 months. The second

> month I was there, in March, she… It was like my mum was saying oh your nan don't want to see you until you've got rid of the baby… And then a couple of months later because I got rid of it she started beating me up again so I had to come back in care…
> (Interview 2:12)

This quote highlights the very disruptive and traumatic nature of some young peoples' lives:

Wanting someone to love

The connections between pregnancy, motherhood and seeking affection and love is a sentiment that was echoed by another young woman, again revealing the considerable complications and difficulties faced by some young people:

> They want a baby because it's someone to love and someone to care for because if they're like us, in care and everything,…My first daughter died at 2 months but I only wanted a daughter just to cuddle and give my love to that I couldn't give to anyone else. Do you know what I mean? She didn't survive. But this one, she was a mistake… But now that I've got her I wouldn't be without her. But yeah I wanted a baby for ages to give love and attention to…
> (Interview 6: 10)

3.3.6 Commentary: Attitudes towards sex and relationships

The looked-after young people generally expressed a cautious approach towards sex and relationships. They emphasised the need for protecting oneself from pregnancy and sexually transmitted infections and for the necessary maturity to enter into sexual relationships. The teenagers thought that the best advice to give other young people about sexual health was to wear a condom, but their knowledge was not readily forthcoming and highlighted to some extent deficits in their understanding of the choices available. The looked-after teenagers who had become mothers however, revealed the more complicated reality of sex and relationships, where passions and emotions could override 'sensible' decision-making. This suggests a gap between knowledge and behaviour that cannot necessarily be bridged by greater knowledge. The need for adequate services and support to strengthen contraceptive behaviour and respond to lapses in cover is therefore highlighted.

Many of the young people reported having had a turbulent childhood and upbringing where they had no stability in their home lives, as well as no consistency with professional contact, and this is clearly connected to the difficulties with education and service use explored in this study. Negative educational experiences alongside inadequate parental support and weak social networks have been identified by Cocker and Scott (2006) as denoting an absence of 'resilience promoting factors' in the lives of looked after children, contributing to a tendency towards the younger onset of sexual activity. It is also argued that profoundly disadvantaged children experience an 'accelerated life-course' (Burton, 1997), where they are exposed to adult problems at a younger age and have to mature more rapidly than other children. This 'childhood unsettlement' has been identified by Coleman and Cater as a contributory factor to the tendency of looked-after teenagers to become parents at a young age (Coleman and Cater 2006). Arai also identified amongst a group of teenage mothers, those who had suffered 'severe early life adversity' and who attributed their young motherhood to a desire for love and to correct the wrongs done to them (Arai 2003).

4 Key Points

Sex and Relationships Education

- The sample revealed that disruptions, such as those experienced by our sample, increase the potential for disengagement with teaching staff and learning. In addition, isolation and a feeling of difference from other pupils can all lessen opportunities for SRE education and increase the potential for gaps in knowledge. Teenagers were critical of the education they had received and the methods by which they had received them.

- The handling of potentially embarrassing subjects in large mixed classes appears to have a negative impact on the learning experience. For looked-after young people who may have more tenuous relationships with school colleagues and who may already feel isolated and exposed as different, the potential for embarrassment is maximised.

- Opportunities for one-to-one consultations with sympathetic and knowledgeable adults were particularly highly valued by the looked-after sample, who were often disengaged from school and distrustful of regular teaching staff. In particular, looked-after children appeared to be more used to dealing with health and social care professionals and therefore related well to outside speakers, clinic staff and school nurses.

- Schools appear to have been unable to ascertain what level of sexual health information transient young people have had in the past and what new information they need to know. As a result, what is provided tends to be disparate levels of 'catch-all' sex education to an often wary and disengaged audience. These factors reduce the likelihood of school being a supportive environment in which looked-after children can receive SRE.

Seeking Advice about Sex and Relationships

- While some of the respondents had received some helpful advice from General Practice and sexual health services, issues relating to embarrassment, styles of communication, gender, and expectations of judgement and disapproval clearly impacted upon the decisions of most of our respondents to use these services.

- Young people showed a preference for consulting female doctors and nurses, and male doctors were seen less favourably and perhaps less likely to be consulted about sexual health matters.

- The use of sexual health clinics highlighted both positive and negative experiences. Some young people talked about being treated unfairly and being judged, feeling their wishes and needs had been ignored. Others believed that they could seek advice on a variety of issues such as contraception, abortion and sexual health.

- Respondents held differing opinions on whether they found the staff approachable, but the anticipation and actual experience of negative attitudes had the potential to act as a deterrent.

- Other barriers to attendance at sexual health clinics were hours of opening. There was little consensus about the opening times and location of sexual health clinics, but being familiarised with such services through school or other sources of SRE was endorsed. Some preferred lunchtime access, others thought after-school sessions were more suitable.

- Foster parents were identified by many as a key source of support and advice, some were more wary of confiding in carers and others had experienced serial breakdowns of fostering relations.

- Sources of information reliant on telephone or internet access were overwhelmingly criticised by the sample as unworkable for teenagers who had few resources and little opportunity for the private viewing of websites or confidential use of landlines.

- The young people were relatively knowledgeable about condoms and hormonal contraceptives and where to access them. However, this knowledge varied greatly between individuals and may have been more concrete amongst those who were sexually active.

Attitudes towards sex and relationships

- The looked-after young people generally expressed a cautious approach towards sex and relationships. They emphasised the need for protecting oneself from pregnancy and sexually transmitted infections and for the necessary maturity to enter into sexual relationships.

- The teenagers thought that the best advice to give other young people about sexual health was to wear a condom; but their knowledge was not readily forthcoming and highlighted to some extent deficits in their understanding of the choices available.

- Many of the young people reported having had a turbulent childhood and upbringing where they had no stability in their home lives and were unable to form anything but transient relationships with agencies, and this is clearly connected to the difficulties with education and service use explored in this study.

5 Recommendations

Sex and relationships education

Given the disruptions to looked-after young people's schooling caused by their familial backgrounds and moving from one home or placement to another, alternative, more need-based provision for sex education should be ensured. However, this education would be best placed within the holistic framework of educational delivery developed in Kent, perhaps avoiding direct targeting that may induce a sense of 'difference' deemed unacceptable by our sample. There are a number of features identified from this study that correspond to those elicited from the survey and the teenage parent reports and are worth repeating here:

- SRE lessons need to be well-planned, engaging, visual, regular, repeated (recognising the fragmented nature of school attendance) and relevant.

- Smaller classes or group work would provide a better context for learning.

- Attempts to capture interest by using arresting images, practical activities and teaching aids seem to be effective in facilitating recall.

- Specialist training in the particular issues and circumstances faced by looked-after children would be advisable for those who provide sex and relationships information.

Access to sexual health information and services

There are obvious difficulties in providing a consistent service and trying to foster long-term relationships with looked-after teenagers that could improve service uptake. However, it essential that alternative sources of information and support are made more widely available to looked-after children. Some suggestions for improvements are outlined below:

- Attempts should be made to ensure that looked-after teenagers have the opportunity to be engaged in local initiatives such as the C cards, which would overcome barriers to access to condoms such as requiring appointments, screening or unwanted advice.

- Within the school setting, condoms should be widely available and freely distributed. There were divergent preferences for more confidential, out-of-school services and for in-school services via school nurses.

- Those delivering the service to looked-after teenagers should make every effort to adopt a non-judgemental attitude and be empathetic towards the emotional needs of this population group.

- Establishing long-term relationships with health professionals would also be helpful given the transience described by young people as characterising their relationships with social workers and other professionals.

- With respect to opening times for services, suggestions for improvement included opening clinics during school lunch-hours and for a few hours after school in the afternoon, as well as bringing contraceptive services into the school on a regular basis and familiarising pupils with clinics in their locality.

- 'Great Expectations' Training in sexual health should continue for foster parents the Kent.

6 Conclusion

This small qualitative study has acted as an adjunct to the main survey data with the intention of including the views of more hard to reach young people, and has elicited some useful insights into both the particular views and experiences of looked-after teenagers and those they share with other young people.

Overall, the deficits in sex and relationships education that appeared to predominate, seemed to have been created from two different pathways; firstly brought on by disruptions, difficulties in engagement and criticisms regarding delivery from the perspective of the respondents; and secondly by the schools' inability to identify the specific knowledge requirements of this mobile, wary and isolated population group. Even the knowledge that the respondents received was not regarded as of value, emphasising more the need for greater 'goodness of fit' between requirements and information giving. Mistrustfulness emanating from the significant emotional upheavals experienced by the teenagers as they live their lives spills over to how relationships are formed for all authority figures, including those professionals they need to engage with for sexual health education and services. This creates further vulnerabilities as the young people start to engage in relationships of their own.

There were considerable methodological difficulties experienced during this study regarding accessing the sample groups and adequacy of recruitment. This resulted in the study being conducted with a smaller sample than originally hoped for at the design stage. The problems faced in building the sample reinforces our understanding of difficulties described by other researchers in reaching children living outside birth families and within a service that is often subject to changes of structure and personnel. In turn, this highlights the difficulties of instability and lack of support faced by looked-after children themselves and emphasise the importance of research that seeks to provide further knowledge of their particular experience with a view to improving the way they are cared for by health and social care professionals. Despite these difficulties, the study has served to underpin previous knowledge in this area and revealed some specific concerns in relation to local service provision. It has also provided justification for continued targeting of this very vulnerable population group.

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Appendix One: Interview schedule

Personal Characteristics
Could you tell me a bit about yourself?

age, school or employment, living arrangements, when you go out or what you like to do, your relationships with friends, family and/ or carers

Sex and Relationships Education
Can you tell me about the sex and relationships education that you've received?

Where did you get most of your information?
What kind of information were you given?
What sources of information did you trust or value the most?

Looking back, do you think you were given any information on sex and relationships too early or too late?

What would you have liked people to have told you?
When would you have liked to receive this information?
How would you have liked to receive this information?

What did you think about the people who taught you?

How comfortable did you feel with teachers or outside speakers?

Could you tell me what you liked and what you didn't like about the sex and relationships education that you had?

Sexual Health Services
Where do you think you would go for advice about sex, pregnancy or contraception?

Is there anything that would make it easier for you to get advice?
Is there anything that would stop you from getting advice?
Are you aware of the 4 young people logo and website?
Have you used it? How did you find it?

Have you ever asked for support or advice about sexual health or relationships?

Can you tell me about the service or support that you received?
What did you like or dislike about them?
What were their main strengths or weaknesses?

Would you be able to ask your carers and/ or parents about sex and relationships?

What helped or stopped you from doing this?

What part of sexual health and relationships services do you think is the most important?

Confidentiality (privacy), young staff, availability of contraception, pregnancy tests, information on sexual health, support groups, etc…

What do you think could be done to make sex and relationships education and services for young people better?

Access to services? Time and location
The right information at the right time?

How well do you think your sex and relationships education, and any experiences of sexual health services have prepared you for the rest of you life?

Do you think you have enough information on
sexual feelings and emotions
contraception
abortion
pregnancy
being a parent
sexually transmitted infections
responsibility in relationships
drinking and drug use and having sex?

Summary
Could you tell me your best and worst experiences of sex and relationships education?

Could you tell me your best and worst experiences of sexual health services, if any?

What do you think is the most important or best advice that could be given to young people like yourselves on sex and relationships?

Is there anything I haven't asked you that you thought I would?

Appendix Two: Information sheet given to potential recruits

Teenagers' Views of Sex and Relationships Education and Sexual Health Services

My name is Jan Macvarish and I am part of a team at the University of Kent who have been asked to carry out a project by the Kent Teenage Pregnancy Partnership.

I would like to invite you to take part in the project.

Before you decide if you want to take part or not, it is important that you understand what the project is about.

What is the project about?
This project will find out what young people think about sex and relationships education and sexual health services in Kent.

Your answers will be used to make the services better in the future so that they meet the needs of young people, and so your views and experiences are very important.

If I take part what do I have to do?
You will need to take part in a group discussion with other young people.

We will be talking about things like where you get your information about sex and relationships from, what you think about this information, and where you might go to for help and advice.

If you allow me to, I will tape record our discussion that will last about 40 minutes, depending on how much you want to tell me.

What happens to the information?
I would like you to know that anything you tell me will stay with me, and your information will be completely confidential.

Your answers will be coded, which means that they will not have your name with them and so they cannot be traced back to you.

Any information that has been recorded in the project, such as tapes or documents, will be destroyed when the project is finished.

Do I have to take part?
It is up to you if you take part or not, but if you don't want to take part, this will not affect you in any way. If you decide to take part you can also change your mind at any time during the group.

How can I find out more?
If you would like to know more about the project or if there is anything that is not clear, you can contact me (Jan Macvarish) on 01227 823666 during office hours, or leave a message and I will call you back.